TOTAL BODY
WELLNESS GROUP

Cavi-Lipo™ Client Intake Form

Personal Information

Last Name	First Name	M.I.

Date of Birth	E-mail

Mailing Address

City	State	Zip Code

Home Phone — May we leave a message at this number? ○ Yes ○ No

Alternate Phone — May we leave a message at this number? ○ Yes ○ No

Occupation	Hours per Week

Medical Provider Information

Primary Healthcare Provider	Last Visit

Location of Your Provider

Health Information

Primary Health Concerns

Past Hospitalizations

Past Surgeries

Current Medications

Current Supplements

Allergies (food/drug/environmental)

Current Exercise (type and frequency)

Do you smoke? ○ Yes ○ No ○ Previously

Do drink caffeine? ○ Yes ○ No ○ Previously

How often do you drink alcohol?

Do you have, or have you ever had, any of the following (check all that apply):

- ☐ Anemia
- ☐ Anorexia or Bulemia
- ☐ Anxiety Disorder
- ☐ Any Psychiatric Disorder
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Chronic Constipation
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Lung Problems
- ☐ Diabetes
- ☐ Eye Problems
- ☐ Frequent Headaches
- ☐ Heart Attack or Angina
- ☐ Heart Murmurs
- ☐ Heart Palpitations
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol Triglycerides
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Low Blood Sugar
- ☐ Neurological Disorders
- ☐ Panic Attacks
- ☐ PMS or Hot Flashes
- ☐ Seizures or Epilepsy
- ☐ Shortness of Breath
- ☐ Swollen Ankles
- ☐ Thyroid Problems
- ☐ Other _____

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If you checked off any of the conditions on the previous page, please provide further details:

Female Client Only

Start date of your last menstrual cycle	Are you breastfeeding? O Yes O No
Are you pregnant or trying to get pregnant? O Yes O No O Trying O Using birth control	

Family History

Cancer O Yes O No	If yes, who?
Diabetes O Yes O No	If yes, who?
Obesity O Yes O No	If yes, who?
Heart Disease or Stroke O Yes O No	If yes, who?

Nutrition & Diet

Do you follow a particular diet? O Yes O No	If yes, please describe:
Have you gained or lost weight recently? O Yes O No	If yes, please describe:
What are the names of the weight loss programs or diets that you have tried?	
Do you drink diet soda or use artificial sweeteners? O Yes O No	
Do you normally eat breakfast? O Yes O No	
Do you regularly skip meals? O Yes O No	
How much weight would you like to lose?	

Please list foods that you eat regularly for:

Breakfast
Lunch
Dinner
Snacks
Normal water intake

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Signature

My signature below warrants that I have completed this questionnaire truthfully and accurately. My records will be kept confidential and will only be shared with the Cavi-Lipo™ licensed professionals and their staff. My written consent is required for any sharing of information outside of Total Body Wellness.

I understand that the Cavi-Lipo™ licensed professionals and their staff are providing services to me related specifically for, and only to, the treatment of cellulite and adipose tissue reduction.

I understand that any dietary consultation involves a health profile and body composition analysis whose purpose is not to establish a diagnosis, but rather to determine my health status in order to provide recommenations for a diet and exercise regime for the duration of my Cavi-Lipo™ Ultrasound Body Scuplting treatments. I also understand that I may be advised to seek medical advice based on my health profile.

Print Name	
Signature X	Date / /
Legal guardian's signature for minors X	Date / /

How did you hear about the Cavi-Lipo™ Ultrasound Body Scuplting Treatments?

Name of Referral	Relationship
Internet (please be specific)	
Other (please be specific)	

Do you know anyone who has undergone Cavi-Lipo™ Ultrasound Body Scuplting treatments? O Yes O No

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practice. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Total Body Wellness reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Personal Representative (optional)	Relationship
Print Client Name	
Client or Personal Representative Signature X	Date / /

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Consent for Treatment

Please initial each section to indicate that you understand each topic.
Do not initial if you desire more information.

Consent for Treatment

I_____ authorize Total Body Wellness and whomever they designate as their assistants, to assist me in my body sculpting efforts through the use of Cavi-Lipo™ Ultrasound body sculpting. I understand that my procedure is conducted through the use of ultrasound frequency and that clinical results may vary patient to patient. It has also been explained and I understand that to gain the best possible results I should participate in regular exercise, follow the recommended dietary guidelines, consume the recommended water per day and refrain from alcohol consumption. I understand that individual factors including but not limited to medical history, skin type, patient compliance both pre and post treatment and individual response to treatment will directly affect my results. I also understand that Cavi-Lipo™ involves a series of treatments and the fee structure has been explained to me.

Initials: _____

Proposed Treatment

The Cavi-Lipo™ protocol is for treatment of adipose areas and cellulite through a series of 3-6 Ultrasound Body Sculpting treatments (Some patients may require up to 12 treatments) with intervals of twice a week. A key component to this protocol is a Whole Body Vibration treatment or exercise, such as a brisk walk, immediatly after each treatment. In addition, it is imperative to drink plenty of water 24 hours before and after the treatment, a mimum of 64 ounces per day. Carbohydrate and fat intake must be minimized 24 hours before the treatment to effectively burn and secrete fatty acids and glucose.

Initials: _____

Anticipated Benefit

The Cavi-Lipo™ Ultrasound body sculpting protocol is a non-invasive treatment designed to yield rapid removal of fat deposits such as those found on the belly, thighs, hips, breasts, upper arms, back, and under chin. Clients often report visible results within 1-3 treatment especially when combined with the recommended diet and exercise regime.

Initials: _____

Risks & Complications

I understand that any weight loss treatment may involve risks as well as proposed benefits. Possible side-effects of the Cavi-Lipo™ Ultrasound Body Sculpting procedure may include but are not limited to headache, gastrointestinal disturbances, reddening (erythema) of the skin, blistering, temporary bruising, and psychological mood swings. I also understand that during the treatment I may experience a buzzing or ringing of the ears, heat and pressure to the treatment area. I verify that contraindications for treatment have been explained and all information on my health history is accurate. I understand that withholding information regarding my health history including but not limited to cancer, HIV/AIDS, metal implants, recent surgery and any autoimmune disorder and continuing with treatment may have result in serious medical repercussions.

Initials: _____

Pregnancy & Breastfeeding (female client)

We do not start treatment on a pregnant woman. If a client becomes pregnant during the treatment she is to notify our office and discontinue treatment. Treatment will not be performed while a woman is breastfeeding unless approved by OB/GYN. By signing this consent I assert that I am not pregnant or breastfeeding.

Initials: _____

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Contraindications

PLEASE initial by each of the following - I confirm the following items to be true and accurate:

_____ I am not pregnant, nursing or lactating at this time
_____ I do not have a pace maker or defibrillator
_____ I do not have any heart condition
_____ I do not have liver or kidney disease
_____ I do not have a contagious or infectious skin disease
_____ I have not had or have cancer
_____ I do not have Aids, HIV or Hep C
_____ I do not have metal implants

_____ I do not have any conditions that the MediPro Direct Slim™/ Cavi-Lipo™ staff should be aware of.

Initials: _____

Addition Support Programs and Products

I undertand that I have the option to include any of the Total Body Wellness weight management programs or products to aid in supporting the diet and exercise recommended with the Cavi-Lipo™ Ultrasound Body Sculpting protocol and to help further stimulate fat metabolism.

Initials: _____

Release Form

I (the undersigned) hereby grant to Total Body Wellness the right to photograph me and authorize the anonymous use of my picture, photograph, silhouette and other reproductions of my physical likeness for medical research, education, and marketing/promotions. I agree that I will not assert or maintain against MediPro Direct Slim™, your successors, assigns and licensees, any claim, action, suit or demand of any kind or nature whatsoever, including but not limited to those grounded upon invasion of privacy, rights of publicity or other civil rights, or for any reason in connection with your authorized use of my physical likeness and sound in the projects as herein provided. I hereby certify and represent that I am over 18 years of age and have read the foregoing and fully understand the meaning and effect thereof.

Initials: _____

Signature

I have carefully read and initialed the preceding sections of this consent for treatment for I understand that although the Cavi-Lipo™ Ultrasound Body Sculpting equipment has been approved by the Food & Drug Administration for cellulite and adipose tissue treatment should not be seen as a substitute for other weight-reducing measures but as an additional aid to a healthy diet and exercise regime recommended by the Cavi-Lipo™ licensed professionals. My questions have been answered satisfactorily by the medical professionals and their associates. With this knowledge, I voluntarily consent to participate in Cavi-Lipo™ ultrasound body sculpting. I realize that the staff at Total Body Wellness has made no absolute guarantees to me regarding results. I understand that I am free to discontinue participation in this treatment program at any time. I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications. I am fully aware that my condition is of cosmetic concern and the decision to proceed is based solely on my expressed desire to do so and there are no refunds. I agree to the use of arbitration to settle legal controversies that may arise as part of my treatment program.

Print Name	
Signature **X**	Date / /
Legal guardian's signature for minors **X**	Date / /

Disclaimer

Cellulite and adipose tissue reduction results will vary from person to person. No individual result should be seen as typical. The Cavi-Lipo™ ultrasound cavation technology has been approved by the FDA. The Cavi-Lipo™ Ultrasound Body Sculpting treatments are not a substitute for other weight-reducing measures such as proper diet and exercise. Results not guaranteed.

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Statement of Privacy Practices

Office Policy

Our office is dedicated to protect the privacy rights of our clients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal HealthCare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Probability and Accountability Act and the state of Washington. This personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future clients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality healthcare, implement payment activities, conduct normal healthcare practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc.. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental official under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail/answering machine messages, postcards, newsletters and special events.

Client Rights

You have the right to request copies of your healthcare information; to request copies in various formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for use other than stated above. All such requests must be in writing. We may charge you for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a client at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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Cancellation Policy

Signature

I understand that I will pay for my sessions at the time service is rendered. I agree to cancel/or reschedule my sessions at least 24 hours in advance. If I don't give 24 hours notice. I understand that failure to cancel any scheduled appointment 24 hours prior to treatment may result in Total Body Wellness applying the missed treatment to any prepaid packages.

I have read this disclosure in detail and I understand the terms and refund/cancellation policy.

Print Name	
Signature **X**	Date / /

Please send me e-mail specials and news

Name	
E-mail	

We will never share your email address with another subscription provider or third party vendor.